State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE



CITATION NUMBER: 220018226

Date: 12/20/2022 12:00:00 AM

Type Of Visit:

YOU ARE HEREBY FOUND IN VIOLATION OF APPLICABLE CALIFORNIA STATUTES AND REGULATIONS OR APPLICABLE FEDERAL STATUTES AND REGULATIONS

Incident/Complaint No.(s) : CA00795631

Licensee Name: City & County of San Francisco, Dept. Public Health

Address: 375 Laguna Honda Blvd. San Francisco, CA 94116

License Number: 220000040 Type of Ownership: County

Facility Name: LAGUNA HONDA HOSPITAL & REHABILITATION CTR D/P SNF

Address: 375 Laguna Honda Blvd San Francisco, CA 94116

Telephone : (415) 759-2300

Facility Type: Skilled Nursing Facility Capacity: 769

Facility ID: 220000512

| SECTIONS VIOLATED | CLASS AND NATURE OF VIOLATIONS | PENALTY ASSESSMENT | DEADLINE FOR COMPLIANCE |
|---|---|---|---|
| | CLASS: B<br>CITATION: Patient Care | 3000.00 | 1/3/2023 8:00:00 AM |

T22 DIV5 CH3 ART5-72523(a)
T22 DIV5 CH3 ART3-72311(a)(1)(B)
1336.2(a)(1)(2)(3A)(3B)(4)(5)
1336.2(b)
T22 DIV5 CH3 ART3-72311(a)(2)

**CLASS** B **CITATION --** Patient Care

T22 DIV5 CH3 ART3-72311(a)(1)(B) Nursing Service - General

(a) Nursing service shall include, but not be limited to, the following:
(1) Planning of patient care, which shall include at least the following:
(B) Development of an individual, written patient care plan which indicates the care to be given the objectives to be accomplished and the professional discipline responsible for each element of care. Objectives shall be measurable and time-limited.

T22 DIV5 CH3 ART3-72311(a)(2) Nursing Service - General

(a) Nursing service shall include, but not be limited to, the following:
(2) Implementing of each patient's care plan according to the methods indicated. Each patient's care shall be based on this plan.

Name Of Evaluator:
Anabel Macaraig
HFEN

Evaluator Signature:_____

Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE

Signature:_____

Name:_____

Title:_____

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T22 DIV5 CH3 ART5-72523(a) Patient Care Policies and Procedures
(a) Written patient care policies and procedures shall be established and implemented to ensure that patient related goals and facility objectives are achieved.

1336.2(a)(1)(2)(3A)(3B)(4)(5) Health & Safety Code DIV2 CH2 ART8.5

(a) Before residents are transferred due to any change in the status of the license or operation of a facility, including a facility closure or voluntary or involuntary termination of a facility's Medi-Cal or Medicare certification, the facility shall take reasonable steps to transfer affected residents safely and minimize possible transfer trauma by, at a minimum, doing all of the following:

(1) Be responsible for ensuring that the resident's attending physician or the facility medical director, if the resident does not have an attending physician, completes the medical assessment of the resident's condition and susceptibility to adverse health consequences, including psychosocial effects, prior to written notice of transfer being given to the resident. The assessment shall not be considered complete unless it provides, in accordance with these assessments, recommendations for counseling, follow-up visits, and other recommended services, by designated health professionals, and for preventing or ameliorating potential adverse health consequences in the event of transfer.

(2) Be responsible for ensuring that a licensed marriage and family therapist, a licensed clinical social worker, a licensed psychologist, a licensed psychiatrist, or a licensed professional clinical counselor and the facility nursing staff complete an assessment of the social and physical functioning of the resident based on the relevant portions of the minimum data set, as described in Section 14110.15 of the Welfare and Institutions Code, before written notice of transfer is given to the resident. The assessment shall not be considered complete unless it provides recommendations for preventing or ameliorating potential adverse health consequences in the event of transfer. The assessment may be amended because of a change in the resident's health care needs. The assessment shall also include a recommendation for the type of facility that would best meet the resident's needs.

(3) (A) Be responsible for evaluating the relocation needs of the resident including proximity to the resident's representative and determine the most appropriate and available type of future care and services for the resident before written notice of transfer is given to the resident or the resident's representative. The health facility shall discuss the evaluation and medical assessment with the resident or the resident's representative and make the evaluation and assessment part of the medical records for transfer.

(B) If the resident or resident's representative chooses to make a transfer prior to completion of assessments, the facility shall inform the resident or the resident's representative, in writing, of the importance of obtaining the assessments and follow-up consultation.

(4) At least 60 days in advance of the transfer, inform the resident or the resident's representative of alternative facilities that are available and adequate to meet resident and family needs.

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(5) Arrange for appropriate future medical care and services, unless the resident or resident's representative has otherwise made these arrangements. This requirement does not obligate a facility to pay for future care and services.

1336.2(b) Health & Safety Code DIV2 CH2 ART8.5

(b) The facility shall provide an appropriate team of professional staff to perform the services required in subdivision (a).

The Statute is not met as evidenced by:

Based on interview and record review, the facility failed to:
1. Develop an individualized patient care plan (CP) for discharge planning, and to address risk of transfer trauma for Patient 31.
2. Implement a patient care plan to address high risk of transfer trauma for Patient 31.
3. Implement its written policies and procedures requiring development and implementation of an individualized care plan for discharge planning and to address risk of transfer trauma.
4.Take reasonable steps to transfer Patient 31 safely and minimize possible transfer trauma by not ensuring that the patient's attending physician or the facility medical director, a licensed clinical social worker, and nursing staff properly performed complete assessments of Patient 31.
5.Take reasonable steps to transfer Patient 31 safely and minimize possible transfer trauma by not arranging for appropriate future medical care and services for Patient 31.

These failures had the potential to result in Patient 31 not receiving continuity of care and for the patient to experience physical, mental, and emotional trauma following relocation to a different skilled nursing facility.

Findings:

On 8/2/22, at 9 AM, the California Department of Public Health (CDPH) conducted an unannounced complaint investigation at the facility to ensure the safe transfer of residents related to the facility's certification termination and pending closure.

Patient 31 was a 68 y/o female, admitted on 7/16/2013, with diagnoses including dementia (decline in memory or other thinking skills). Patient 31 is conserved under the SF Public Guardian.

A review of Patient 31's Minimum Data Set (MDS, a standardized assessment tool) dated 6/18/22, indicated severe impairment to make decisions regarding tasks of daily life. Patient 31 was described as, rarely/never understands and rarely/never understood. Under functional status, Resident 3 requires one person physical assistance in performance of Activities of Daily Living (ADL's). Patient 31 was totally dependent with mobility, transfer, dressing, eating, personal hygiene and toilet use. Patient 31 is non

ambulatory (unable to walk).

A review of Resident Care Team (RCT) Meeting notes from the transferring facility, dated 5/18/22, indicated, "…Problem: Transfer Trauma. Transfer trauma interventions: ... Continue to assess for any emotional and/or behavioral changes such as increased anxiety or withdrawal. Refer to Psychiatry consult if needed to address transfer trauma. Goal: Demonstrate ability to cope with hospitalization/illness. Description: Assess and monitor patients' ability to cope with his/her illness. Interventions: 1. Encourage verbalization of feelings/concerns/expectations... 3. Assist patient to identify own strengths and abilities, 4. Encourage patient to set small goals for self. 4 encourage participation in diversional activities. Reinforce positive adaptation of new coping behaviors..."

A review of Physician Discharge Summary from the transferring facility, dated 7/11/22, indicated, "…Mental status/Cognitive Assessment: (Patient) is socially inappropriate but passive and cooperative with the interview as at her usual baseline. Her appearance was unremarkable, and she was alert. She has no speech or language at her usual baseline and therefore I was unable to assess her thought content or thought process or depression or hallucinations or orientation. She has no insight into her mental condition, and she has no judgement for her care. She has obvious abnormalities with attention concentration and memory…"

During an interview on 8/16/22, at 11:37 AM, with Licensed Clinical Social Worker (LCSW) related to transfer trauma intervention, "to assess Patient 31 for any emotional and/or behavioral changes such as increased anxiety or withdrawal," LCSW stated, "It is a general observation, there's no other documentation."

During an interview on 9/7/22, at 3:27 PM, with Nurse Manager 5 (NM 5) related to transfer trauma care plan interventions, NM 5 stated, "She (Patient 31) was not interviewable. She won't be able to verbalize. She couldn't express herself. We shouldn't have used the word verbalized." NM 5 acknowledged there was no evidence of documentation Patient 31 was assessed for any emotional and/or behavioral changes such as anxiety or withdrawal as related to transfer trauma.

Review of facility's policy titled, "Resident Care Plan (RCP), Resident Care Team (RCT) & Resident Care Conference (RCC)" revised 7/9/19 indicated, "Policy…2. The RCT in conjunction with the resident, resident's family, or surrogate decision-maker, shall develop a comprehensive care plan, based on the care team disciplines' assessments, that includes measurable objectives and a time table to meet the resident's medical, nursing, and mental health needs. 3. The Resident Care Plan (RCP) shall be person-centered, evaluated during weekly or monthly summaries, when indicated for short term problems, every quarter, and revised as needed to serve as an essential resource for improved resident outcomes…Procedure: 1. The Resident Care Team a. The RCT is an essential component of the care planning process. The RCT shall include members from those disciplines essential to the planning and delivery of care for the resident. RCT members include: i. Nurse Mangers (or designee) – Facilitator of RCC ii. Licensed Nurse iii. Nursing Assistant iv. Attending Physician v. Medical Social Worker vi. MDS Coordinator vii. Activity Therapist viii. Registered Dietitian…7. Developing Interventions…b. Interventions are specific, individualized and describes the team member(s) responsible for carrying it out and the frequency for conducting the interventions. c. Interventions reflect standards of

current professional practice…"
A review of the "Facility Closure Plan" dated 5/03/22, indicated, "…Facility Closure Team Role and Responsibilities…Each staff member that is a part of each Resident Care Team will have a role in the transfer and relocation process to assure a safe and orderly transfer for all patients…Nursing Services…Implement the general scope of nursing practice, including promotion of health, prevention of illness, and care of physically ill. Supervises other health auxiliaries. Ensure that each patient's care plan is in place and continues throughout the closure process…"

Review of (the facility's) Notification of Closure and Patient Transfer and Relocation Plan, submitted to the Department and Centers for Medicare and Medicaid Services (CMS) on 5/13/22, under Part 1- Notification Requirements indicated, "Notice to individual Patient of Proposed Transfer/Discharge (per Health and Safety Code1336.2(a)(3)). These notices will be sent out on a patient-by-patient based on the individualized needs of each patient after the assessment is done to minimize the possibility of what is called transfer trauma, or the stress that the person may experience when changing living environments." Under Part 2 – Patient Assessment indicated, "… Because of likely placement delays, these assessments will be conducted every 3 months (quarterly) from the initial assessment date (each a re-assessment). These re-assessments will take in considerations any changes in condition or clinical/nursing care needs that may affect a patient's level of care. The 3 month cadence of re-assessment will continue until the patient is transferred or discharged from Laguna Honda…To achieve the overall goal of helping patient's move to a new location, the facility will maintain a patient focused discharge process. The facility will provide services such as social services and psychiatric support to minimize stress to patient and or Representative…"

Patient 31 was transferred to another facility on 7/13/2022.

During an interview on 9/27/22, at 11:05 AM, Infection Preventionist from the receiving facility stated, the facility had a COVID-19 outbreak that started on 7/12/22.

During an interview on 10/3/22, at 4:05 PM, Transfer Coordinators (TC 1 and TC 2) from the transferring facility stated that they were aware of the COVID-19 outbreak at the receiving facility when they discussed resident placement in the facility and when they transferred Patient 31 to the receiving facility.

A review of the nurse's notes at the receiving facility indicated that Patient 31 developed fever and was diagnosed with COVID – 19 Infection on 7/21/22, and shortness of breath requiring oxygen supplementation on 7/22/22.

Patient 31 passed away on 7/24/22.

In violation of the above cited standards, the facility failed to comply with its established written patient care policies and procedures, Patient Transfer and Relocation Plan, Title 22 regulations, and Health and Safety Code section 1336.2, including but not limited to failing to develop and implement an individualized care plan to address Patient 31's risk for transfer trauma, and take reasonable steps to minimize possible transfer trauma by performing complete assessments and arranging for appropriate future medical care and services. These failures had the potential to result in Patient 31 not receiving continuity of

care and for the patient to experience physical, mental, and emotional trauma following relocation to a different skilled nursing facility.

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